Ontario

Premier's Council on
Health Strategy

TOWARDS HEALTH OUTCOMES

GOALS 2 AND 4: OBJECTIVES AND TARGETS

A VISION OF HEALTH

We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work, and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender, or cultural background. Finally, we see everyone working together to achieve better health for all.

GOALS

1. Shift the emphasis to health promotion and disease prevention.
2. Foster strong and supportive families and communities
3. Ensure a safe, high quality physical environment.
4. Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.
5. Provide accessible, affordable, appropriate health services for all.

TOWARDS HEALTH OUTCOMES

GOALS 2 AND 4: OBJECTIVES AND TARGETS

Health Goals Committee

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March, 1991

The Honourable Bob Rae
Premier of Ontario
Queen's Park
Toronto, Ontario

Dear Premier Rae:

The Health Goals Committee of the Premier's Council on Health Strategy is pleased to present to you the completed work on objectives and targets for Health Goal 2, *Foster strong and supportive families and communities*; and Health Goal 4, *Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.*

Our work began three years ago with the development of a Vision of Health for the citizens of Ontario. The vision is based on a view of health that extends well beyond conventional views to include an understanding that people are most likely to realize their full health potential when they live in safe and supportive communities, in healthy environments, with adequate incomes and housing and with meaningful and rewarding roles in life. Of course, equitable access to an excellent health care system is also essential.

The Health Goals Committee particularly recognizes that we must all work together to achieve this vision. Through the process of developing health goals and strategies, there is an opportunity for people across the province to participate. Indeed, hundreds of people have participated in the development of this report.

Health Goals provide a tool for establishing a framework for policy reform and priority setting, and for health planning directed towards specific outcomes. When the process is followed through to the target-setting stage at provincial and local levels, the opportunity exists to evaluate our success in improving the health status of our population.

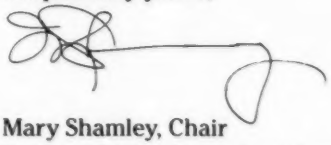
.../2

Adding more money to an already sizable health care budget will not necessarily improve the health status of Ontario's citizens. A more strategic approach to determining needs and establishing priorities is needed if we are to offer the best hope for Ontario's future health.

This report articulates the specific outcomes that a large number of people have concluded would help to define achievement of the vision of health expressed in two of the five health goals.

We encourage the government to provide leadership in developing policy and planning processes directed towards specific outcomes in improved health.

Respectfully yours,



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ACKNOWLEDGEMENTS

The Health Goals Committee would like to give thanks to the many people who contributed to the development of this document.

Foremost, the committee would like to thank the members of the working groups who gave freely of their time and knowledge to translate broad goals into more specific objectives and targets.

In addition, many individuals from the health care and social service community, from academic institutions and from government and non-government organizations, provided input into the process. Their contribution was invaluable, and the committee extends its appreciation to all who participated. Working group members and others consulted are identified in Appendices A and B for Goals 2 and 4, respectively.

The committee also wishes to thank Gary Posen, Deputy Minister, Ministry of the Environment, Dr. Myrna Francis, Director of the Health Promotion Branch, Ministry of Health, and Michael McEwen, Director of Health Planning Branch, Ministry of Health, for their contribution to the work of the committee.

As well, the committee extends its appreciation to the staff of the Premier's Council on Health Strategy, Dr. Terry Sullivan and Anne Larson, for their efforts in managing the committee's work.

Finally, the committee gives thanks to the consultants who were involved in the process, Michele Harding of M. Harding Consulting and Josie d'Avernas of RBJ Health Management Associates. Ms Harding was responsible for facilitating the work of the Goal 2 working group. Ms d'Avernas was responsible for facilitating the work of the Goal 4 working group and for drafting this report.

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BACKGROUND

In 1987, the Government of Ontario commissioned three major reports[1] on health and health care. These reports proposed a philosophy, identified goals and a policy framework, and reviewed the current status of health promotion in the province. In addition, the reports emphasized consumer involvement and community participation in health. The establishment of the Premier's Council was a specific outcome of these reports.

The mission of the Council is to "provide leadership and guidance to the whole government in achieving the goal of health for every citizen of Ontario." The Council has adopted the World Health Organization's definition of health. It views health not only as the absence of disease but also as a positive resource that allows people to cope with, adapt to, or influence the pressures of daily living. These concepts are reflected in the vision of health for the province, and the goals established by the Council. These are Ontario's *first* goals, and represent first steps toward making the vision a reality.

The vision and goals were adopted by the government in the throne speech in the spring of 1989, and released as the first report of the Health Goals Committee in the document *A Vision of Health*.

The first term of reference of the Premier's Council on Health Strategy stated that the Council should:

> *"Select specific goals to achieve improved health of Ontario's residents and establish specific targets and priorities which can be measured, evaluated and implemented with a view to publishing periodic reports of progress in achieving these goals."*

The Health Goals Committee was established in 1987 with a mandate that included the development of prioritized health goals and the development of a process for translating the goals into specific objectives and targets.

Health goals provide a basis for establishing a framework for policy reform and priority-setting, and for outcome-oriented planning. When the process is followed through to the target setting stage at provincial and local levels, the opportunity exists to evaluate our success in improving the health status of our population. The process itself offers an opportunity for people across the province to participate in developing strategies to improve their own health.

This document is the second report of the Health Goals Committee, and was approved by Council in January of 1991. Its primary focus is on the development of objectives and targets for Goal 2, "Foster strong and supportive families and communities" and Goal 4, "Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death."

This report describes the process developed by the committee and currently being applied to the development of objectives and targets for Goal 3, "Ensure a safe high-quality physical environment," which will follow shortly as a companion document.

These three goals address two major determinants of health (social and environmental), as well as disease-specific risk factors, disease conditions and disabilities themselves. Specific objectives and targets have not yet been developed for Goals 1 and 5, but they have clearly influenced other work of the Council. Goal 1, "Shift the emphasis to health

1. • *Toward a Shared Direction for Health in Ontario*
   • *Health Promotion Matters in Ontario*
   • *Health for All Ontario*

promotion and disease prevention," is strongly reflected in the recent report of the Healthy Public Policy Committee, *Nurturing Health*. Goal 5, "Provide accessible, affordable, appropriate health services for all," is in many ways addressed through the work of the Health Care System Committee in its reports *From Vision To Action* and *Achieving the Vision: Health Human Resources*; and by the work of the Integration and Co-ordination Committee in its recent report *Local Decision Making for Health and Social Services in the Community*. All of these reports are available from the office of the Premier's Council on Health, Well-Being and Social Justice.

The Goals Process

The establishment of goals, objectives and targets represents only the beginning of a process designed to bring about fundamental change. The first five goals lay the foundation for other goals to follow. Objectives and targets had to be carefully chosen to provide a workable beginning. They do not represent all that was considered or all that can be done. The need to adopt an incremental approach and to set priorities, however difficult this may be, became clear when the work of other jurisdictions was studied. The committee set out to keep the number of objectives for each goal under 10, and the number of targets for each objective also under 10.

The work of the committee extended beyond the establishment of goals, objectives and targets to the consideration of strategies that allow other key players in the system to adopt and commit to use these tools. The committee has also studied the need to develop mechanisms to measure progress in the achievement of the Vision and Goals.

Health goals can become a driving force in systems that affect health and in shaping public policy, but not on their own. They must be translated into action that is relevant at provincial and local levels.

DEFINITIONS

Goal:	Broad statement of a desired change around which planning efforts can be organized. This is an ideal statement of what should exist.
Objective:	More specific statement of desired change, in measurable form.
Target:	Statement that defines the amount of change strived for, and the time frame in which it is to be achieved.
Operational Plan:	Statements that spell out specific mechanisms for change and strategies for implementing them. These are made at the level of individual government departments and local planning bodies.

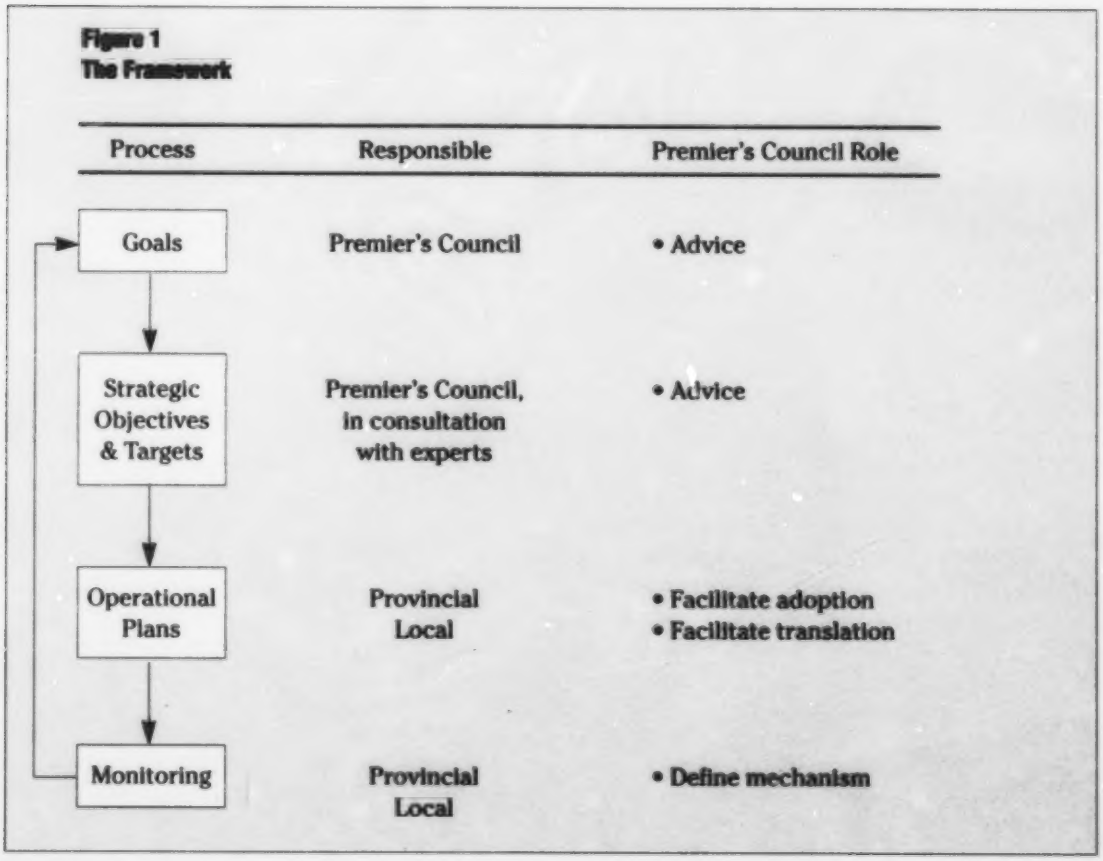
The framework adopted by the committee for Goals 2, 3 and 4 is depicted in Figure 1. The Health Goals Committee established working groups for each of the three goals with a mandate to translate the goals into objectives and targets. Each goal was translated into more specific statements of intent or objectives. Targets supporting each objective define the amount of change desired and the date by which it is to be achieved. At every stage, the committee and the working groups engaged in extensive consultations and sought technical expert input to ensure that the work reflected the most up-to-date perspectives and data. (see Appendix A & B)

The criteria developed for objectives and targets included relevance to the goal, feasibility, the severity of the problem addressed, clarity, measurability to the extent possible, and targets that allow for regional and local variation. Targets are part of a process designed to bring about change; they are not an end in themselves. They should be adjusted over time as feedback is obtained and results are measured, and to reflect changing priorities.

Figure 1 refers to objectives and targets as "strategic" because they are intended to set the direction for change at a provincial level, in keeping with the role of the Premier's Council. They are not intended to dictate specific solutions. Government, provincial, regional and local planning groups are urged to translate these strategic objectives and targets into operational plans that respect local mandates, needs and structures. Responsibility for the planning and implementation of programs and services needed to bring about change lies at many levels in the system.

Background reports that include a menu of possible mechanisms for implementing objectives and targets are available from the office of the Premier's Council, for those who are interested in the substantial research undertaken by the working groups.

Figure 1
The Framework



The goals process is really a dynamic cycle in which feedback is critical to making progress in the achievement of our vision. The development of a process for monitoring outcomes, such as through the Ontario Health Survey, will provide the last link in the goals process.

It is hoped this report on objectives and targets will stimulate both the development of healthy public policy and provincial, regional and local planning directed at seeking specific outcomes in improved health for Ontarians. While this work seeks to establish the provincial direction, it is designed to foster creativity in the development of strategies at all levels, and to allow for local variation and priority-setting. To achieve success, commitment to the process by all levels of government, the community and by individuals will be essential.

GOAL 2:
OBJECTIVES AND TARGETS

FOSTER STRONG AND SUPPORTIVE FAMILIES AND COMMUNITIES.

GOAL 2:

FOSTER STRONG AND SUPPORTIVE FAMILIES AND COMMUNITIES.

Goal 2 emphasizes the importance of the social environment to health. Four principles exemplify healthy families and communities: interdependence, social responsibility and participation, equity in health, and a useful role in society. Five conditions were identified as determinants of health from the point of view of fostering healthy families and communities: adequate income, education, occupation, shelter, and control of life conditions. Hence, Goal 2 objectives and targets are aimed at improving health by bettering social and physical environments – for instance, through changes in social service and housing policy.

Objectives and targets for this goal do not represent everything that can be done. Rather, they represent priority areas that will require periodic review and revision. The following criteria were applied in selecting priorities for action:

- relevant to the goal
- interventions exist that are available and effective
- address problems that are frequent, severe and/or long lasting
- economically and politically feasible within the assigned time frame
- clear, technically accurate and easily understood
- allow for regional and local development of specific strategies by groups responsible for implementation.

The order of presentation of the objectives and targets does not imply order of importance.

Measurability was also considered as a criterion because measurable objectives and targets provide a clear means of monitoring progress. However, some of the targets in this report are not targets in the strict sense of the word, in that it is not possible with current data to specify a target amount of change. Nevertheless, they are included and the development of data systems to allow progress to be monitored is urged. Once baseline data become available, these targets should be reviewed and quantified. They are included at this time in the hope that they will not only stimulate action toward development of appropriate data bases, but also enhance commitment to the policies needed to achieve the targets.

OBJECTIVE 2.1

PROVIDE OPPORTUNITIES FOR PEOPLE TO MEET THEIR ECONOMIC NEEDS.

An adequate income and safe, meaningful employment are major determinants of health and well-being. Priority for intervention should be given to recipients of social assistance, low-wage/low-skilled workers, employable disabled persons, displaced workers, and single-parent families.

Targets

2.1.1 By 2000, provide more employment opportunities by developing and establishing economic development strategies tailored to local economies.

Community economic development marshals both public and private resources at the local level to encourage the development of enterprises and the creation of jobs that serve both the economic and social needs of the community. Priority for government assistance should be given to unstable or poor local economies.

2.1.2 From 1995, ensure that social assistance payments cover the actual cost of a basic range of necessary goods and services consistent with overall community standards of living. (Necessary goods and services include food, household maintenance costs, clothing, recreation, transportation and insurance.)

There is a need to determine the non-shelter requirements of social assistance recipients more accurately, so that payments can be made according to need. There is also a need for payment levels to keep up with changes in the cost of living. Therefore, an evaluation of options for determining, on an ongoing basis, the cash value of the non-shelter needs of these recipients should be undertaken.

2.1.3 By 1995, develop programs to support employment for low wage workers and employable people with disabilities to ensure they are better off through employment.

Employment fosters self-esteem and a sense of self-worth. Low wage workers and persons with disabilities are at high risk for employment insecurity and poverty. Programs to support employment can ensure they are better off economically through employment than through social assistance.

2.1.4 By 1995, enhance economic security for displaced workers by increasing the proportion of workers covered by programs: for re-employment; for protection from unpaid wages and benefits; for retraining for older workers; and for retirement preparation.

Workers displaced by major layoffs, plant down-sizing, closure or relocation can face insecure futures, particularly older workers, and those with low levels of education. Re-employment programs can promote their economic security. Mechanisms to protect workers' unpaid wages and benefits in the case of employer insolvency, receivership or bankruptcy can also enhance the workers' economic security. The average retirement age is decreasing. Life expectancy is increasing. These factors magnify the importance of assessing and planning for economic needs in retirement. This should occur well before the anticipated date of retirement.

2.1.5 By 2000, reduce the level of unemployment among employable people with disabilities to that of the nondisabled population.

Persons with disabilities who can and wish to work should have access to the labour market; they should be provided with reasonable personal and environmental employment supports, including physical access, suitable work environments, suitable transportation, and training/skills development programs.

OBJECTIVE 2.2

EMPOWER COMMUNITY MEMBERS TO INFLUENCE POLICY, PROGRAMMING AND THE ALLOCATION AND MANAGEMENT OF RESOURCES RELATING TO HEALTH AND SOCIAL SERVICES.

Empowerment means giving people both the opportunity and capability to participate in decisions that affect programming, policy and physical environments. Participation in community governance structures and institutions is an effective mechanism through which individuals and communities may gain greater control over their life conditions.

Targets

2.2.1 By 2000, ensure that the representation of consumers of health and social services be at least one third of the membership on governance structures.

Governance structures include governmental and quasi-governmental authorities and committees, and boards of publicly funded agencies, that are responsible for policy, program and resource allocation decisions. Consumers include potential and current users of the service who do not represent a service provider or managerial voice. Assistance should be given to members to enable their participation (for example, scheduling meetings so that members can attend without undue hardship or loss of income and offering orientation and training as needed).

2.2.2 Starting immediately, work together with local and regional structures so that by 2000 an appropriate level of authority for planning, allocating and managing resources for health and social services is achieved.

The responsiveness, accountability and effectiveness of health and social services may be improved by decentralized decision making. However, responsibility cannot be effectively transferred without a transfer of appropriate resources, authority and accountability.

OBJECTIVE 2.3

PROVIDE HABITATS THAT SUPPORT HEALTH AND WELL-BEING.

Habitats are more than shelter. They are also transportation, access to green space, communication systems and other systems that are the infrastructure for human activities. However, adequate and appropriate shelter is being emphasized at present, because of the deficiency of accessible, affordable rental housing, and transitional and emergency housing in many Ontario communities. Objectives for healthy physical environments are presented under Goal 3.

Targets

2.3.1 By 1993, increase to 100% the percentage of municipalities that have a plan for development and approval of accessible, affordable, non-profit rental housing units to meet the needs of the population.

Municipalities should work together with the Ministry of Housing and the Ministry of Municipal Affairs in development of these plans.

2.3.2 Until the year 2000, fund the production of not less than 10,000 non-profit rental units per year.

2.3.3 By 1992, have in place, in each municipality, a plan to have transitional housing and emergency shelters available to all people in need.

Emergency housing includes accommodation and support services currently provided under the following programs: emergency shelter and assistance; family violence shelters and counselling; and emergency shelters. Transitional housing includes halfway houses and rehabilitation programs in addition to the more traditional rooming- and boarding-house accommodation for low-income individuals. The plan should be tailored to each municipality, and developed jointly by the municipality, provincial government and voluntary agencies.

2.3.4 By 2000, substantially reduce the barriers to independence faced by disabled persons by increasing the accessibility of buildings and implementing specialized, demand-responsive transportation systems.

Accessibility for people with all disabilities should be considered in building design, room design and transportation systems. This includes mobility disabilities, as well as visual, hearing, speech, cognitive and other disabilities.

2.3.5 By 2000, increase the target proportion of special needs housing units within non-profit projects from 10% to 12%.

OBJECTIVE 2.4

PROVIDE ALL ONTARIANS WITH EQUITABLE ACCESS TO QUALITY LIFE-LONG EDUCATION.

People's knowledge and skills affect their opportunities for economic well-being, as well as their capacity to act on information to protect and improve individual and community health. Particularly, health education should be given adequate time and emphasis in the school curriculum.

Targets

2.4.1 By 2000, increase to 95% the proportion of adult Ontarians who are functionally literate.

2.4.2 By 2000, have in place improved local mechanisms (developed jointly by government, educators, business/industry and organized labour) to link skill and knowledge formation and retraining to the requirements of the economy.

Worker preparation should be a shared responsibility of the community (through the education system), business/labour sectors (through apprentice, upgrading and retraining mechanisms) and government. Opportunities for retraining in response to changing technology should be available over the life course.

2.4.3 By 1995, develop, in 10% of schools, new, innovative and specific programs aimed at reducing violent and aggressive behaviour, and by 2000, implement effective models of tolerance, co-operation and non-violent behaviour in all schools.

The multicultural, multiracial nature of Ontario creates a need to change attitudes that are barriers to integration and participation in society on the basis of geography, income, age, gender, disability or cultural background. Schools offer an appropriate and available context for socializing children to tolerance and co-operation. Effective models to eliminate "bullying behaviour" in children in the early school years have been implemented in Norway (e.g., "Anti-bullying in the schools" by Dr. Daniel Olweus). Such models should be implemented and evaluated in Ontario.

2.4.4 By 2000, increase to at least 95% the proportion of adolescents who are adequately informed of the social, psychological, ethical and medical implications of sexuality.

Adolescent sexual activity in the context of ignorance and high risk can create grave social consequences. The risk of sexually transmitted diseases (including AIDS) and pregnancy are increased with inadequate information or misinformation.

OBJECTIVE 2.5

INCREASE EFFORTS TO ASSIST FAMILY MEMBERS AND NEIGHBOURS TO CARE FOR EACH OTHER AND FOR OTHER MEMBERS OF THEIR COMMUNITY.

The availability and quality of one's social support network is a determinant of health and well-being. Many elderly people, low-income youth, sole-support parents, and people with chronic physical or mental illness or disability require varying levels of support to live in the community. Caregiver support should be fostered through identification and monitoring of natural helpers, provision of relevant information, counselling and training, availability of respite care and support for professional services.

Targets

2.5.1 Until 1995, increase the number of licensed child-care opportunities by 12% per year.

Child-care is more than licensed day care. A range of child-care opportunities is needed to meet the needs of both working and non-working parents. This includes additional child-care spaces in community facilities, especially subsidized spaces for lower-income parents. It also includes neighbourhood-based parent/child resource programs, encompassing such things as toy-lending services, parenting workshops, drop-in centres, and information and referral services.

2.5.2 By 1995, develop employment strategies to balance work and family care responsibilities.

Parental support strategies are needed, such as flexible working arrangements (e.g., for a sick child), parental leave with job security, and reduced working hours with pro-rated benefits.

2.5.3 Redirect resources within the health care envelope so that by 2000, resource allocation to community services is doubled to 10%.

We currently over-emphasize inpatient care and have not fully developed ambulatory and community programs. The bulk of the Ontario Ministry of Health's budget goes to institutions and payment of drug benefits, and insurable services. Only 5% is allocated to community services, including public health, community mental health and addictions, and home care.

Community services are shaped by and offered to people who live in close proximity. The emphasis is shifted to the local level and the enhancement of independent living in the community. Non-professionals, volunteers, family, friends and neighbours join professionals as partners in care.

In some cases, community services represent a less costly alternative to institutional care. However, many types of community services do not serve groups who would otherwise be in institutions. There are reasons for improving community services that extend beyond cost-effectiveness. These include quality of life, flexibility, client independence, family burden and individual preference.

2.5.4 By 2000, reduce the incidence of violence against both women and children by 50%.

Violence against women and children occurs in families of all socio-economic, educational and cultural backgrounds. Some groups may, however, seek help more readily and be more likely to have the financial resources and supportive networks necessary for escape.

2.5.5 By 1995, increase by 25% school-based psycho-social programs aimed at preventing, identifying and treating psycho-social problems.

Schools are an important environment in which to identify problems. Better linkage with community-based social services and agencies are necessary for appropriate referral. Psycho-social programs include outreach to parents to identify and assist in early resolution of problems, improved systems to monitor signs of academic or personal difficulties promptly, before- and after-school care programs and parent education programs.

OBJECTIVE 2.6

INCREASE RESEARCH AND DATABASE DEVELOPMENT TO PROVIDE BASELINE INFORMATION AND FACILITATE MEASUREMENT OF PROGRESS TOWARDS ACHIEVING THESE OBJECTIVES AND TARGETS.

Some of the targets in this report are not specific because that is not possible with current data. They are nevertheless included, and the development of data systems to allow progress to be monitored is urged. Once baseline data becomes available, these targets should be reviewed and quantified.

GOAL 4:
OBJECTIVES AND TARGETS

INCREASE THE NUMBER OF YEARS OF GOOD HEALTH FOR THE CITIZENS OF ONTARIO BY REDUCING ILLNESS, DISABILITY AND PREMATURE DEATH.

GOAL 4:

INCREASE THE NUMBER OF YEARS OF GOOD HEALTH FOR THE CITIZENS OF ONTARIO BY REDUCING ILLNESS, DISABILITY AND PREMATURE DEATH.

The only one of the five goals that directly addresses *disease*, Goal 4 has objectives that reflect a more traditional view of health as the absence of disease. It is noted that the absence of disease remains a critical component of the new, broader definition of health. The Council recognizes that "reducing illness, disability, and premature death" is not all that it takes to "increase the number of years of good health for the citizens of Ontario," according to the new Vision of Health. However, these concepts defined the boundaries for this goal. The objectives and targets for the remaining goals would focus on the other important dimensions of health.

This does not imply that the focus is strictly on treatment of illness. The objectives for this goal evolved from a priority setting exercise based on the major causes of mortality, morbidity and disability. All levels of intervention, from primary prevention through treatment and rehabilitation were considered. Thus, objectives and targets were set for the reduction of risk factors for disease and disability, and for the reduction of the disease conditions themselves.

As for Goal 2, objectives and targets for this goal do not represent everything that can be done. Rather, they represent priority areas that will require periodic review and revision. The following criteria were applied in selecting priorities for action:

- relevant to the goal
- interventions exist that are available and effective
- address problems that are frequent, severe and/or long lasting
- economically and politically feasible within the assigned time frame
- clear, technically accurate and easily understood
- allow for regional and local development of specific strategies by groups responsible for implementation
- measurable.

The order of presentation for objectives and targets does not imply order of importance.

In line with the committee's terms of reference, the list of objectives represents a defensible set of priorities.

OBJECTIVE 4.1

REDUCE TOBACCO USE.

Tobacco use is the single most important preventable cause of death and disease in Ontario. It is responsible for 25% of deaths among adults age 35 and over, or more than 13,000 deaths annually. Second-hand smoke also contributes to disease, including lung cancer. Smoking in pregnancy increases the risk of miscarriage, stillbirth and low birthweight.

The need for concerted action to first reduce, then eliminate smoking is unquestionable. A sustained program of varied initiatives is essential. It should combine policy, programming and research, and be aimed at prevention of smoking, cessation, and protection from second-hand smoke.

Targets

4.1.1. By 2000, reduce total tobacco sales by at least 50%, and by at least 5% in each year of the 1990s.

4.1.2. By 2000, reduce the percentage of young people aged 12-19 who smoke, from a current (1986) rate of approximately 19% to 10%.

4.1.3. By 2000, reduce the percentage of women who smoke from a current (1986) rate of 24% to 15%.

4.1.4. By 2000, reduce the percentage of men who smoke from a current (1986) rate of 28% to 15%.

4.1.5. By 1995, increase to 100% the percentage of schools, workplaces and public places that are smoke-free.

4.1.6. By 1995, eliminate sales of tobacco products to minors.

4.1.7. By 2000, eliminate the use of tobacco products by pregnant women.

OBJECTIVE 4.2

REDUCE THE HAZARDOUS USE OF ALCOHOL.

An estimated 6000 deaths per year in Ontario are due to alcohol. It is involved in approximately 50% of fatal traffic accidents and in nearly half of all fatal intentional injuries, such a suicides and homicides. Abuse of alcohol by young people is associated with school failure, delinquency, and perhaps unwanted pregnancy. In adults, excessive alcohol use is implicated in violence in the home and unemployment, as well as in a host of medical problems.

Efforts to reduce alcohol-related problems should occur in the context of a comprehensive program that includes policy, programming and research and addresses prevention and treatment.

Targets

4.2.1. By 2000, reduce the average annual adult consumption of alcohol by 25%, from 10.6 litres of pure alcohol per year to 8 litres per year.

4.2.2. By 2000, reduce alcohol-involved motor vehicle accidents by 50%, from 25% of all motor vehicle accidents to 12%.

4.2.3. By 2000, reduce the use of alcohol among young people aged 12-18 by 50%.

4.2.4. By 2000, reduce the incidence of fetal alcohol syndrome by 25%.

OBJECTIVE 4.3

INCREASE THE PROPORTION OF THE POPULATION PRACTISING HEALTHY EATING AND PHYSICAL ACTIVITY HABITS.

Dietary factors, particularly fat intake, play a prominent role in heart disease, stroke, hypertension, cancer and diabetes. Diet is also related to osteoporosis, obesity and dental disease. Physical inactivity is also a risk factor for heart disease, independently, and through the development of other risk factors like obesity, hypertension and high-risk blood lipid profiles. Physical activity can help mental health problems, particularly those related to depression. It protects against osteoporosis. It can also improve functional capacity in the elderly, prolonging the time before the "threshold for dependence" is reached.

Targets

4.3.1. By 2000, reduce the consumption of dietary fat by 20%, from 38% (1986) to 30% of total calories (or less than 15% of foodstuff).

4.3.2. By 2000, increase to at least 50% the percentage of people age 18 and older who participate in physical activity equivalent to daily brisk walking for at least 60 minutes.

4.3.3. By 2000, increase to 100% the percentage of children in Grades K to OAC who participate in daily physical activity within the school program.

4.3.4. By 2000, reduce the percentage of adults who have a body weight-for-height that puts them at increased risk to health (BMI > 25) by 33%, from 30% (1986) to 25%.

BMI (Body Mass Index) is a measure of weight-for-height and is the weight in kilograms divided by the square of height in metres.

OBJECTIVE 4.4

REDUCE ILLNESS, DISABILITY AND PREMATURE DEATH FROM HEART DISEASE AND STROKE.

Heart disease and stroke account for over one-third of all deaths in Ontario. They also represent the leading cause of disability. Their incidence has declined in the last 30 years, due to such factors as changes in lifestyle (dietary changes, reductions in smoking), improved drugs to treat arrhythmias, improved surgical techniques, better identification and treatment of hypertension, declines in rheumatic heart disease, and the emergence of cardiac care units.

Further decreases in heart disease and stroke can be expected with further reductions in smoking, hypertension and serum cholesterol, and with further improvement and co-ordination of diagnostic, treatment and rehabilitation services.

Targets

4.4.1. By 2000, reduce by 45% illness, disability and premature death due to stroke.

4.4.2. By 2000, reduce by 35% illness, disability and premature death due to atherosclerotic heart disease.

4.4.3. By 2000, fulfil the targets for smoking, nutrition and physical activity (see objectives 4.1 and 4.3).

4.4.4. By 2000, reduce by 50% the percentage of people with diastolic blood pressure greater than 100 mmHg.

4.4.5. By 1995, have in place an integrated cardiovascular disease control program for Ontario, which co-ordinates and extends into the community prevention, early diagnosis, treatment and rehabilitation activities, rationalizes resource allocation and evaluates program effectiveness.

OBJECTIVE 4.5

REDUCE ILLNESS, DISABILITY AND PREMATURE DEATH FROM CANCER.

Cancer is the largest contributor to Potential Years of Life Lost in Ontario. Projections of the cancer burden for the year 2001 predict almost 60,000 new cases per year compared with just over 20,000 in 1970 and 34,000 in 1986. The leading cancer contributors to premature loss of life are lung and colorectal cancers in males, and breast and lung cancers in females.

Achievement of this objective requires the development and implementation of a comprehensive cancer control program for Ontario that encompasses primary prevention, early detection and screening, active cancer treatment, rehabilitation, psycho-social support and palliative care.

Targets

4.5.1. By 2000, reduce mortality from cancer by 10% in people under age 65.

4.5.2. By 2000, reduce morbidity and disability from cancer.

4.5.3. By 1995, have in place an integrated cancer control program for Ontario, which co-ordinates and extends into the community prevention, early diagnosis, treatment and rehabilitation activities, rationalizes resource allocation and evaluates program effectiveness.

4.5.4. By 2000, fulfil targets for smoking and nutrition (see objectives 4.1 and 4.3).

4.5.5. By 2000, achieve screening for breast cancer in 70% of the target population (women age 50-69).

4.5.6. By 2000, achieve screening for cervical cancer in 90% of the target population (sexually active women age 18-64).

4.5.7. By 2000, increase the availability of radiotherapy facilities to permit the provision of appropriate radiotherapy to those newly diagnosed cases that require it (approximately 45% of new cases).

OBJECTIVE 4.6

REDUCE ILLNESS, DISABILITY AND PREMATURE DEATH ARISING FROM MENTAL ILLNESS.

In recent years there have been over 9,000 admissions annually to inpatient beds in provincial psychiatric hospitals, and over 36,000 to psychiatric units in general hospitals. Patients with schizophrenia occupy over 7% of all hospital beds - the second-largest number of beds occupied for one disease. Mental disorders, particularly schizophrenia, often produce chronic, life-long impairment. Thus, the targets under objective 7 (disability) also relate to this objective. Suicide is the fourth leading cause of premature mortality in Ontario for females, and the third for males. Suicide is a measurable aspect of mental disease.

The targets under this objective focus on mental illness as opposed to mental health because of the difficulty in measuring the latter. Continuing research to identify indicators of positive mental health is important, as is research into the factors contributing to mental illness and health.

Targets

4.6.1. By 2000, reduce the overall suicide rate in Ontario by 47%, from its present level of 11.4 per 100,000 to 6.0 per 100,000.

4.6.2. By 2000, increase by 10% the number of people with schizophrenia who have full-time or part-time jobs.

4.6.3. By 2000, reduce disability arising from schizophrenia and dementias of the Alzheimer type.

OBJECTIVE 4.7

REDUCE DISABILITY AMONG PHYSICALLY AND MENTALLY IMPAIRED CITIZENS AND INCREASE THEIR INTEGRATION INTO THE COMMUNITY.

The cost of institutional care and income support for persons with disabilities in Ontario is in the range of $5 to $6 billion per year. More than half of all disabilities are musculoskeletal in origin, with arthritis being the most common. Other common disabilities include vision and hearing disorders, chronic mental illness, learning disabilities, genetically transmitted disabilities, brain trauma and developmental disorders.

The reduction of disability requires interventions to prevent underlying disease, to minimize impairment where disease is manifested, and to minimize handicapping effects. Strategies are diverse and go well beyond the traditional health system to include housing, transport, welfare and education.

Targets

4.7.1. By 2000, reduce the incidence of disablement due to musculoskeletal and sensory disorders.

4.7.2. By 2000, reduce disability arising from developmental impairment.

4.7.3. By 2000, reduce the incidence of disablement due to disorders of the circulatory system, cancer, mental illness, AIDS, and motor vehicle accidents by fulfilling the targets for these health areas (see objective 4.4, 4.5, 4.6, 4.9 and 4.10).

4.7.4. By 2000, reduce handicap arising from disabilities by fulfilling targets 2.1.3., 2.1.5., 2.3.4., and 2.3.5. under Goal 2.

4.7.5. By 1995, have in place an integrated program for the reduction of disability and handicap, which co-ordinates and extends into the community program activities, rationalizes resource allocation and evaluates program effectiveness.

OBJECTIVE 4.8

REDUCE PERINATAL AND INFANT MORTALITY AND LONG-TERM MORBIDITY OF PERINATAL ORIGIN.

Perinatal deaths (stillborn fetuses and neonatal deaths) represent the fifth-highest cause of life years lost in Ontario. Perinatal and infant mortality increases as birthweight decreases. The effective strategies of other societies in the prevention of low birthweight should be researched and vigorously pursued as a provincial priority.

Low birthweight can be reduced by early identification of those at high risk for low birthweight delivery, proper treatment, and continued surveillance and research.

Targets

4.8.1. By 2000, reduce the low birthweight rate by 43%, from 5.3.% (1987) to 3%.

4.8.2. By 2000, reduce perinatal mortality among those of low birthweight by 40%, from 9.9% to 6%.

4.8.3. By 1995, reduce the burden of morbidity of perinatal origin by ensuring that 100% of newborns receive appropriate perinatal care.

4.8.4. By 1993, have in place surveillance systems which allow systematic assessment of perinatal morbidity and congenital anomalies.

4.8.5. By 2000, increase to 100% the proportion of health regions in Ontario that have comprehensive parent support programs in place.

OBJECTIVE 4.9

REDUCE ILLNESS, DISABILITY AND PREMATURE DEATH FROM AIDS AND HIV INFECTION.

It is not possible to set quantifiable targets for this objective because our current knowledge of the prevalence of HIV infection and AIDS is incomplete. Nevertheless, AIDS and HIV infection are targeted because of their epidemic nature once introduced into a population.

AIDS compromises the immune system, leaving people vulnerable to a host of infections. No cure or vaccine is currently available.

Reducing morbidity and mortality from HIV infection requires a reduction in transmission, as well as adequate and dignified management of each infected person.

Targets

4.9.1. By 1995, reduce the spread of HIV infection in the population.

4.9.2. By 2000, increase the average number of years between detection of HIV infection and progression to symptomatic AIDS and terminal illness.

4.9.3. By 1995, increase the number and knowledge base of health care providers providing adequate and effective treatment and care to people living with AIDS and HIV infection.

4.9.4. By 2000, increase the knowledge base of all medical and social aspects of HIV infection and AIDS.

4.9.5. By 1995, improve the provision of supportive social environments for people living with AIDS and HIV infection, including housing, community and social services.

OBJECTIVE 4.10

REDUCE INJURY AND DEATH ARISING FROM MOTOR VEHICLE TRAFFIC ACCIDENTS.

Accidental injuries are the second leading cause of death in Ontario when measured by Potential Years of Life Lost. The principal cause of death and disability from accidental injuries are those associated with motor vehicle traffic accidents. In 1987, there were about 121,000 Ontarians injured, and 1,126 killed as a result of such accidents.

A combination of education, policy (e.g., with respect to alcohol) and environmental control factors (speed limits, road and car design) is needed to reduce the consequences of motor vehicle traffic accidents.

Targets

4.10.1. By 2000, reduce motor vehicle traffic accidents by 15%, from 326 per 100 million kilometres travelled to 277 (or from 347 per 10,000 vehicles registered [1986] to 297).

4.10.2. By 2000, reduce the death rate due to motor vehicle traffic accidents (MVTA) in the 0-14 age group by 41%, from 3.4 per 100,000 to less than 2 per 100,000.

4.10.3. By 2000, reduce the death rate due to MVTA in the 15-24 age group by 22%, from 25.6 per 100,000 to 20 per 100,000.

4.10.4. By 2000, reduce the death rate due to MVTA in the 25-34 age group by 22%, from 16.6 per 100,000 to 13 per 100,000.

4.10.5. By 2000, have in place data systems to allow measurement and monitoring of illness and disability resulting from MVTA.

4.10.6. By 2000, increase compliance regarding adult restraint use in cars to 95%.

4.10.7. By 2000, increase compliance regarding infant and child carrier use in cars to 95%.

OBJECTIVE 4.11

INCREASE FUNDING FOR RESEARCH IN ALL OF THESE PRIORITY AREAS, BEYOND THE RATE OF INFLATION AND USING NEW RESEARCH DOLLARS. INCLUDE BEHAVIOURAL RESEARCH AIMED AT THE PREVENTION OF DISEASE.

For many of the objectives, a multi-sector approach is called for. Reducing major health problems requires an orderly sequence from research to the broad, systematic application of research results. These results must be applied along the entire continuum of intervention, including prevention, early detection, treatment, and social and physical rehabilitation. Knowledge of the effectiveness of various courses of action is essential. Building this knowledge base requires ongoing surveillance of disease and risk factors in the population, as well as basic and applied research.

Research should not be limited to that on medical conditions, or even on the determinants of disease. Research on the determinants of ***health****, and on how to modify them to enhance health, is as important. We are increasingly aware of the limits in what medicine can achieve, and of the much larger scope for health improvement that could come from a deeper understanding of these determinants including family structures, income, housing, psychological factors such as perceived control and motivation, and social support.*

APPENDIX A. HEALTH GOALS COMMITTEE MANDATE

Introduction

The Evans and Spasoff reports urge the Province to develop and implement a health goals process. The reports state that:

> "We suggest that the Premier's Council must first define specific goals to achieve the improved health of Ontario's residents." (*Toward a Shared Direction for Health in Ontario*)

> "...health goals can provide an objective basis for evaluation of health programs, and for the planning of subsequent policies and programs." (*Health for All Ontario*)

Health goals emerged as one of the key principles in interviews that were carried out with Council members.

Interviews and discussions indicated that it would not be possible to meet all goals at once but that it was important to accept the philosophy and to establish priorities.

Terms of Reference

The Health Goals Committee of the Premier's Council on Health Strategy shall be chaired by a member of Council and will be composed primarily of Council members. Regular progress reports will be made at each Council meeting.

The terms of reference for the committee are as follows:

1. To propose for Council's review a set of priorized health goals for adoption by Council. In developing the goals the committee shall review the report *Health for All Ontario* and other factors considered relevant.
2. To develop for Council's review a process for translating the goals into specific objectives.
3. To recommend to Council options for carrying out the process; including resources, immediate and long term initiatives, reporting mechanism and other relevant features required for implementation.

APPENDIX B. THE CONSULTATION PROCESS FOR GOAL 2

The Health Goals Committee established a working group for Goal 2 in October 1989 as a first step in establishing objectives and targets for Ontario's health goals.

This group was mandated to:

1. Develop a set of criteria to guide the establishment of priority objectives.
2. Set seven to 10 objectives and targets at the provincial level for Goal 2 using the year 2000 as the time frame.
3. Develop an appropriate and manageable consultation process to test draft objectives and targets.

MEMBERS, GOAL 2 WORKING GROUP

Dr. Miriam Rossi (Chair), Faculty of Medicine, University of Toronto, Premier's Council on Health Strategy

Susan Berlin, Canadian Healthy Communities Project

Ronald Book, Mayor, Town of Grimsby

Jennifer Harris, Citizens for Public Justice and Social Assistance Review Committee Network

Grant Lowery, YMCA

Dr. Colin Maloney, Children's Aid Society

Dr. Victor Marshall, Centre for Studies on Aging, University of Toronto

Dr. Peter Playfair, Ontario Advisory Council on the Physically Disabled

Shanthi Radcliffe, Intercommunity Health Centre, London

Frances Sewards, Trustee, Sault Ste. Marie Board of Education

Colin Wasacase, Ojibway Tribal Family Services

ADDITIONAL CONSULTATION

The Health Goals Committee directed that there be a broad consultative approach taken in the establishment of objectives and targets for each of the health goals.

1) Expert Input to Draft Objectives

Experts and key interest groups in selected areas were consulted to identify the most significant issues, trends and opportunities in these areas. Further consultations were conducted to verify the feasibility of proposed targets and the implications of implementing them.

Expert input was received from the following:

Anne Bassett

Gloria Bock, Ministry of Education

Sam Carr, Ministry of Housing

Sue Colley, Day Care Coalition

Evan Collins

Kay Eastham

Peter Elston, Ontario Public Health Association

Dr. Ben Gotlieb, Department of Psychology, University of Guelph

Nicholas Ignatieff, Ministry of Labour

Dr. Laura Johnston

Suzanne Klein, Ministry of Labour

Lori Kociol, Self-Help Clearinghouse of Metropolitan Toronto

Rosemary Langhout, Income Maintenance Br., Ministry of Community & Social Service

Bruce McLeod, Ministry of Municipal Affairs

Jeffrey Patterson, Social Planning Council of Metro Toronto

Helen Riley, Ministry of Community & Social Services

Roy Saunders, Ministry of Labour

Clem Sauve, Office for Disabled Persons

George Smith, Ontario Institute for Studies in Eduction

John Stapleton, Ministry of Community & Social Services

Dr. Simon Sutcliffe

Tracy Westell, Ontario Literacy Coalition

Elise Zack, Ontario Literacy Coalition

Helmut Zisser, Ministry of Skills Development

2) Public Consultation

In March 1990, representatives of health care providers, employers, government, consumer, labour, district health councils, professional associations and universities attended a 1 1/2 day conference.

Participants had been sent a draft of the Goal 2 objectives and targets. At the workshop, attendees discussed these issues:

- Are the objectives sufficient to move toward the goals?
- Are the targets sufficient to achieve the objective?
- Do the targets reflect the "right" amount of change?

The following individuals/groups participated:

Prof. David Adams, Ontario Association of Professional Social Workers

Roy Adams, Association of Municipalities of Ontario

Sonny Arrojado, Association of Ontario Health Centres

Dr. Dick Barnhorst, Child Youth & Family Policy Res. Centre

Rick Beker, Molson Companies of Canada Limited

Susan Berlin, Canadian Healthy Communities Project, Goal 2 Working Group

Dr. Steven Birch, Centre for Health Economics & Policy

Ronald Book, Mayor, Town of Grimsby, Goal 2 Working Group

Danny Caplan, Lawrence Heights Medical Centre

David Carlisle, Network Videotex Inc.

Patrick Carson, Loblaw Companies Limited

Lea Cohen, Ryerson Polytechnical Institute

Dr. Peter Cole, Peel Region Health Department

Coralynn Craig, Canadian Fitness & Lifestyles Research Institute

Audrey Danaher, Planned Parenthood

Dan Drown, Canadian Institute of Child Health

Steve Elson, Niagara District Health Council

Jeff Evenson, Ministry of Housing

Martha Friendly, Ontario Coalition of Better Daycare

Dr. Ralph Garber, Faculty of Social Work, University of Toronto

Mary-Lou Giniac, Long Term Health Care, Ministry of Health

Fiona Green, New Directions for Women

Susan Hall, Ontario Public School Board Association

Linda Ham, Atenlos Native Family Violence Services Inc.

Jennifer Harris, Goal 2 Working Group

Elsbeth Heyworth, Dixon Hall

Rev. Dr. Ray Hodgson, Presbyterian Church of Canada

Grant Hopcroft, Association of Municipalities of Ontario

Joan Huzar, Consumers' Association of Canada

Suzanne Jackson, Ontario Public Health Association

Phil Johnston, Regional Municipality of Waterloo

Michael Klejman, Ontario Association, Non-Profit Homes & Services for Seniors

Lori Kociol, Self Help Clearinghouse of Metropolitan Toronto

Ruth Lafarga, Ontario Public School Board Association

Eleanor Lancaster, Region of Niagara

Art Lane, Ontario Public Service Employees Credit Union

Sandra Lang, Ministry of Community & Social Services

Dr. Peter Loranger, Addiction Research Foundation

Grant Lowery, YMCA Metro Toronto, Goal 2 Working Group

Dr. Frank Maidman

Dr. Colin Maloney, Metro Catholic Children's Aid, Goal 2 Working Group

Dr. Pran Manga, University of Ottawa

Ron Marr, Catholic Health Association of Ontario

Dr. Victor Marshall, University of Toronto, Goal 2 Working Group

Garth Martin, Addiction Research Foundation

Susan McDonald, Ontario Advisory Council on Women's Issues

Tom McFadden, A.L.O.H.A.

Bruce McLeod, Ministry of Municipal Affairs

William McManus, Realco Property Limited

Cathy McPherson, Advocacy Resource Centre for the Handicapped

Jim Merrit, Ministry of the Environment

Robert Morton, Ontario Coalition of Non-Profit Organizations Working With Seniors

Gord Morwood, St. Christopher's House

Margaret Moyston Cummings, District Health Council

Anne Musgrave, Advisory Council for Disabled Persons

Dr. Helen Mussallem, QC, Victorian Order of Nurses

Fiona Nelson, Toronto Board of Education

Marcia Nelson, Ministry of Correctional Services

John O'Leary, Frontier College, Beat the Street

Carol Olsen, Metro School Board

Anna Marie Patella, Metro District Health Council

Jeffrey Patterson, Social Planning Council

Wendy Pegonis, RN, Comcare

Susan Pekilis, Ministry of Education

Francis Perkins, Canadian Public Health Association

J. Playfair

Dr. Peter Playfair, Ontario Advisory Council on the Physically Disabled

Dr. Ron Pond, Homewood Health Centre

Raymond Pong, Ministry of Northern Development & Mines

Dr. Marion Powell, Planned Parenthood

Shanthi Radcliffe, London Intercommunity Health Centre, Goal 2 Working Group

Mary Anne Rangam, Canadian Dietetic Association (Ontario Office)

Mary Rappolt, Ministry of Labour

Mr. Brice Rivers, Children's Aid Society of Metro Toronto

Karen Robinson, Belwood's House

John L. Ronson, Blake Cassels & Graydon/Cancer Society

Carolyn Rosenthal, University of Toronto

Laurel Rothman, Ontario Coalition of Better Daycare

Dick Santos, Persons United for Self Help in Ontario

Peggy Schultz, Ontario Prevention Clearinghouse

Archbishop E.W. Scott, Premier's Council on Health Strategy

Malcolm Shookner, North York Interagency Council

Mike Shuster, Region of Hamilton-Wentworth

Val Slobodian, Ontario Teachers' Foundation

Nancy Smith, Alderman, City of Ottawa

Linda Spears, Probation & Community Services Unit

Don Stockdale, Ontario Public Service Employee's Credit Union

Neville Twine, Ontario Social Development Council

Prof. Elaine Vayda, University of Toronto

Colin Wasacase, Ojibway Tribal Family Services, Goal 2 Working Group

Margaret Weiers, The Toronto Star

Prof. Lillian Wells, Faculty of Social Work, University of Toronto

Tracey Westell, Ontario Literacy Coalition

David White, Supportive Housing Coalition of Metro Toronto

Dr. Robina Williams, Ontario Medical Association

Tony Wohlfarth, Canadian Auto Workers

Lorne Zon, Metro Toronto District Health Council

APPENDIX C. THE CONSULTATION PROCESS FOR GOAL 4

The Health Goals Committee established a working group for Goal 4 in October 1989 as a first step in establishing objectives and targets for Ontario's health goals.

This group was mandated to:

1. Develop a set of criteria to guide the establishment of priority objectives.
2. Set seven to 10 objectives and targets at the provincial level for Goal 4 using the year 2000 as the time frame.
3. Develop an appropriate and manageable consultation process to test draft objectives and targets.

MEMBERS, GOAL 4 WORKING GROUP

Dr. John Dirks (Chair), Faculty of Medicine, University of Toronto, Premier's Council on Health Strategy

Dr. Dugal Campbell, Ontario Mental Health Foundation

Linda Gardner, Hassle Free Clinic, Toronto

Dr. Mark Greenberg, Hospital for Sick Children

Dr. Alexander Macpherson, Education Centre for Aging & Health, Chedoke-McMaster Hospital

Dr. Lily Montano, Public Health Branch, Ministry of Health

Dr. Truls Ostbye, Department of Clinical Epidemiology, University of Western Ontario

Shirley Post, Hospital for Sick Children

Tanys Quesnel, Persons United for Self Help, London

ADDITIONAL CONSULTATION

As it had for Goal 2 the Health Goals Committee directed that there be a broad consultative approach taken in the establishment of objectives and targets for Goal 4.

1) Expert Input to Draft Objectives

Thirty-eight individuals were invited to submit a brief and/or make a presentation to the working group in a particular priority area (e.g., smoking, coronary heart disease, disability). They were asked to provide information on:

- the magnitude of the problem
- how the problem could be reduced
- suggested objectives and targets for the priority area.

Expert input was received from the following:

Dr. Harvey Anderson, University of Toronto

Dr. Elizabeth Badley, The Wellesley Hospital

Dr. Henry Barnett, London

Dr. Claire Bombardier, The Wellesley Hospital

Dr. Philip Berger, Toronto

Dr. John Cairns, McMaster University

Dr. Karen Campbell, St. Joseph's Hospital Centre, London

Dr. Howard Cappel, Addiction Research Foundation

Dr. Graham Chance, St. Joseph's Hospital Centre, London

Dr. Aileen Clarke, Ontario Cancer Treatment & Research Foundation

Dr. Henry Dinsdale, Queen's University

Peter Elston, Ontario Public Health Association

Mary Fanning, Toronto General Hospital

John Garcia, Health Promotion Branch, Ministry of Health

Dr. Paul Garfinkel, Toronto General Hospital

Jessica Hill, Ministry of Health

Dr. William Hryniuk, Ontario Cancer Foundation, Hamilton

Dr. Michael Hutcheon, Toronto General Hospital Centre

Dr. Wilburt Keon, University of Ottawa Heart Institute

Dr. Elizabeth Lindsay, Health Promotion Branch, Ministry of Health

Dr. Sandy Logan, Mount Sinai Hospital

Dr. Harold Merskey, London Psychiatric Hospital

Dr. Tony Miller, University of Toronto

Dr. Bill Nelson, Sunnybrook Medical Centre

Dr. Dan Offord, Chedoke-McMaster Hospital

Dr. Michael Rachlis

Jim Rankin, Addiction Research Foundation

Lynn Roblin, Nutrition Consultant

John Ronson, Canadian Cancer Society

Dr. Tom Salerno, St. Michael's Hospital, Toronto

Clem Sauve, Office for Disabled Persons

Dr. Michael Sharratt, Centre for Applied Health Research, Waterloo

Nancy Shosenberg, Women's Health Bureau, Ministry of Health

Dr. Jack Sinclair, McMaster University Medical Centre

Dr. Michael Sole, Centre for Cardiovascular Research

David Sweanor, Non-Smokers' Rights Association

Dr. David Symington

Dr. Evelyn Wallace, Public Health Branch, Ministry of Health

Dr. Don Wasylenki, Clarke Institute of Psychiatry

Dr. David Wesson, Hospital for Sick Children

2) Public Consultation

In March 1990, representatives of health care providers, employers, government, consumer, labour, district health councils, professional associations, and universities attended a 1 1/2 day conference.

Participants had been sent a draft of the Goal 4 objectives and targets. At the workshop, attendees discussed these issues:

- Are the objectives sufficient to move toward the goals?
- Are the targets sufficient to achieve the objective?
- Do the targets reflect the "right" amount of change?

The following participated:

Dennise Albrecht, Sandy Hill Community Health Centre

Russell Armstrong, AIDS Action Now

Dr. Denise Avard, Canadian Institute of Child Health

Dr. Martin Bass, University of Western Ontario

John Bech-Hansen, Metro Toronto Board of Trade

Dr. Ruth Berman, Ontario Psychological Association

Charles Bigenwald, Ontario Ministry of Health

Barbara Burns, Family Service Centre

Dr. David Butler-Jones, A.L.O.H.A.

Dr. Dugal Campbell, Ontario Mental Health Foundation, Goal 4 Working Group

Dr. Karen Campbell, University of Western Ontario

Barbara Cartwright, New Directions for Women, Belmont House

Dr. Graham Chance, University of Western Ontario

Prof. Mary Chipman, Dept. of Preventive Medicine, University of Toronto

Dr. Aileen Clarke, Ontario Cancer Treatment & Research Foundation

Glenna Cole-Slattery, Ontario Nurses Association

Anne Coy, Patients' Rights

Josie d'Avernas, RBJ Health Management Associates

Dr. John Dirks, University of Toronto, Goal 4 Working Group

Joanne Doyle, North Hamilton Comm. Health Centre

Janet Eby, Community Health & Safety Branch, Ontario Hydro

Dr. Myrna Francis, Health Promotion Branch, Ministry of Health

John Garcia, Policy Development & Co-ordination Unit, Health Promotion Branch, Ministry of Health

Linda Gardner, Hassle Free Clinic, Goal 4 Working Group

Prof. Judy Globerman, Faculty of Social Work, University of Toronto

Michael Godeke

Dr. Mark Greenberg, Hospital for Sick Children, Goal 4 Working Group

John Hartman, Family & Children's Services

Brian Hayday, Ontario Prevention Clearinghouse

Carrie Hayward, Union of Ontario Indians

Larry Hershfield, Addiction Research Foundation

Tom Jones, Mayor of Dryden, Ontario

Evelyn Kent, Planned Parenthood of Toronto

Doug Kittle, Ontario Medical Association

Russ Kisby, PARTICIPaction

Dr. David Korn, Donwood Institute

Gordon Kumiga, Cardio Health Co-ord., Ministry of Health

Dorothy Lamont, Canadian Cancer Society (Ontario)

Suzanne Lawson, Arthritis Society

Sidney Lineker, Arthritis Society

Dr. Jack Macdonald, University of Western Ontario

Dr. Sandy Macpherson, McMaster University, Goal 4 Working Group

John Marriott, Comprehensive Health Organization, Ministry of Health

May Mascow, Ryerson Polytechnical Institute

Steven McDonald, Community Information Centre of Metro Toronto

Michael Mendelson, Ministry of Treasury and Economics

Prof. Patrick Mohide, Chedoke-McMaster Hospital

Dr. Lily Montano, Public Health Branch, Ministry of Health, Goal 4 Working Group

Dr. Henry Muggah, St. Joseph's Hospital

Stan Murray, Ministry of Tourism and Recreation

Chief Leona Nahwegahbow, Whitefish River First Nation

Jim O'Neill, Community Health Branch, Ministry of Health

Dr. Truls Ostbye, University of Western Ontario, Goal 4 Working Group

Dr. Grahame Owen, College of Family Physicians

Diane Patychuk, Ontario College of Nurses

Dr. Jim Pettit, Ministry of Agriculture

Dr. Phelan, Chedoke-McMaster Hospital

Helene Polatajka, Ontario Society of Occupational Therapists

Shirley Post, Hospital for Sick Children, Goal 4 Working Group

Tanys Quesnel, PUSH (London), Goal 4 Working Group

Barbara Quinn, Ontario Society of Occupational Therapists

Dr. Michael Rachlis, Consultant, Epidemiology & Health Policy Analysis

Ross Reid, The Lung Association (Ontario)

Dr. Harry Richardson, College of Physicians & Surgeons of Ontario

Dr. Barbara Robertson, Office for Disabled Persons

Beatrix Robinow, Consumers Association Health Com.

Dr. Irving Rootman, Health & Welfare Canada

Helen Saravanamutto, Ontario Association of Professional Social Workers

Dr. Richard Schabas, Public Health Branch, Ministry of Health

Bunny Segal, Ministry of Citizenship & Culture

Ed Segalowitz, Bernard Betel Centre for Creative Living

Dr. Michael Sharratt, Centre for Applied Health Research

Nancy Shosenberg, Women's Health Bureau, Ministry of Health

Dr. Ken Shumak, University of Toronto, Faculty of Medicine

Anne Silversides, The Globe & Mail

Herb Simpson, Traffic Injury Research Foundation of Canada

Dr. Jack Sinclair, McMaster University

Dr. David Surplis, Ontario Dental Association

David Sweanor, Non-Smokers' Rights Association

Sheila Tippet-Sagyas, Canadian Diabetes Association

Elizabeth Townsend, Registered Nurses' Association of Ontario

Joanne Trypuc, Ontario Hospital Association

Michael Walker, Blackburn Group Co.

Dr. Evelyn Wallace, AIDS Co-ordinator, Ministry of Health

Dr. Daniel Wesson, Hospital for Sick Children

Elinor Wilson, Heart & Stroke Foundation of Ontario

Dr. Paul Ziter, Essex County District Health Council

Harry Zwerver, Ontario Association for Community Living

APPENDIX D. EXPERT STUDY GROUP

On receipt of the working group reports, the Health Goals Committee directed an Expert Study Group to examine outstanding issues related to objectives and targets for both Goal 2 and Goal 4.

Members of this group included:

Mary Shamley (Chair), Premier's Council on Health Strategy

Michael McEwen, Ministry of Health

Bruce McLeod, Ministry of Municipal Affairs

Bernice Morrison, Ministry of Municipal Affairs

Dr. Michael Rachlis, Consultant in Health Policy Analysis

Dr. Robert Spasoff, University of Ottawa, Premier's Council on Health Strategy

In addition to the formal consultation mechanisms outlined in these appendices, numerous individuals from government and interest groups provided ad hoc input throughout the process.